e. Plan sponsor's calculated share is [redacted] which would be processed as a claim through ordinary self-funded banking channels.

D. General

We will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, self-funded plan sponsors reimburse us for any payment attributable to their plan when the payments are made. Each customer's results will vary. It is possible that payments paid to a particular provider or health system may be required even if the plan sponsor's own population did not experience the same financial or qualitative improvements. It is also possible that payments will not be paid to a provider even if the customer's own population did experience financial and quality improvements. A report of VBC charges to a plan sponsor will be available on a quarterly basis.

Upon request, we will provide additional information regarding our VBC arrangements.

Pricing Assumptions

- Our arrangement assumes our standard Agreement provisions and claim settlement practices apply unless otherwise stated.
- **Participation Requirement** – A minimum of [redacted] enrolled employees is required to administer the Customer on a self-funded basis.
- **Plan Design** – The products offered are subject to the terms of our Benefit Review document.
- **Claim Fiduciary** – We have been delegated claim fiduciary responsibilities. As claim fiduciary, we'll be responsible for final claim determination and the legal defense of disputed benefit payments. Our appeal administrative services are automatically included when we've been delegated claim fiduciary responsibility.
- **External Review** – External review is included. External review uses outside vendors who coordinate a medical review through their network of outside physician reviewers.
- **Eligibility Transmission** – Our arrangement assumes we'll receive eligibility information daily, from your location(s) and/or by your designated vendor. Our preferred method of submission is via electronic connectivity.
- **Third-Party Audits** – We don't typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.
- **Mental Health/Substance Abuse Benefits** – Our quotation assumed that mental health/substance abuse benefits were included.

- **Prescription Drug Benefits** – Our quotation assumed that prescription drug benefits were excluded. We've included pharmacy data integration from your third-party pharmacy vendor.

- **Additional Products, Programs and Services** – Costs for special services rendered that are not included or assumed in the pricing guarantee will be billed through the claim wire, on a single claim account, when applicable, to separately identify charges. Additional charges that are not collected through the claim wire during the year will either be direct-billed or reconciled in conjunction with the year-end accounting and may result in an adjustment to the final administration charge. For example, you will be subject to additional charges for customized communication materials (with the exception of a custom A1A welcome kit and letter, Custom ID cards), as well as costs associated with custom reporting, booklet and SPD printing, etc. The costs for these types of services will depend upon the actual services performed and will be determined at the time the service is requested.

Banking

We've assumed that you provide funds through a Fed drawdown by Aetna wire transfer for drafts clearing the bank under the self-funded arrangement assumed in this proposal.

Our standard banking arrangement is to request funds when claims have accumulated to more than [redacted] In this arrangement, a wire request is sent to you and/or your bank requesting funds for the total claims from the previous day(s). For most customers, this would mean daily claim wire transfers.

In place of this arrangement, we will request funds for claims on a specific day of the week, Monday. In addition, there will be a month end close out request on the first banking day of each subsequent month.

Banking fees are included in our quoted medical administration fees.

We've assumed you'll use no more than three primary banking lines which are shared across all self-funded products, excluding Flexible Spending Accounts (FSAs). Additional wire lines and customized banking arrangements will result in an adjustment to the proposed pricing.

Compensation

The quoted fees don't include consultant compensation.

Disclosure Statement – We have various programs for compensating agents, brokers and consultants. If you'd like information about compensation programs for which your agent, broker, or consultant is eligible; payments (if any) which we have made to your agent, broker, or consultant; or other material relationships your agent, broker, or consultant may have with us, you may contact your agent, broker, or consultant or your Aetna account representative. Information about our programs for compensating agents, brokers, or consultants is also available at **www.aetna.com**.

Billing Information

- **Fee Change** –Fees can only be changed as provided in the Agreement.

- **Claim Wire Billing Fees** – Claim wire billing fees refers to the portion of the total administrative expenses that are charged through the claim wire as the services are rendered. Fees charged through the claim wire include those described on the Fee Schedule as well as those fees that the parties may subsequently agree to add to the claim wire from time to time. Programs or services that are charged through the claim wire are excluded from the monthly PEPM Administrative Fees as illustrated on the attached financial exhibit(s) and will not appear on the monthly billing statement. Claim wire charges will appear in the claim detail report separated by unique Claim Reporting System (CRS) draft accounts and other monthly reports provided to you.

- **Teladoc** – Teladoc offers members access to quality, affordable General Medical, Behavioral Health, Caregiver and Dermatology services.

  - **General Medical:** Members can receive care for routine common illnesses with a telephone or online video consultation. Teladoc offers a low cost alternative to more expensive emergency room and urgent-care centers when the member's PCP is unavailable. Telephone consults are available in 49 states (not available in ID), and video consults are available in all 50 states. Arkansas and Delaware require a member's first Teladoc visit to be by video; after the requirement is met, the member will be able to choose phone or video for subsequent visits. Consultations are available seven days a week, 24 hours a day.

  - **Caregiver:** Members can add a non-member care recipient onto their existing Teladoc account to initiate a three-way visit between a physician, caregiver and care recipient. This is a direct to consumer service through Teladoc, available only to access the general medical services. You cannot purchase Caregiver without the General Medical services.

  - **Behavioral Health:** Members can speak with a Behavioral Health provider via an online video consultation. Consultations are available seven days a week, 7 am to 9 pm local time. You cannot purchase Behavioral Health without the General Medical services.

- **Dermatology:** Members can work with a Dermatologist through 'store and forward' technology where the member provides pictures and a questionnaire to the provider via Teladoc and receive communication back. There is no actual video or telephone appointment. You cannot purchase Dermatology without the General Medical services.

Program	Administration Fee PEPM	Per Consult Claim Charge*
[redacted]		

*While this is the total cost that is charged to the member for a consult (depending on the provider level), what a member actually pays depends on how you choose to setup and implement Teladoc. In general, the member will pay a copay amount and the remaining balance (of the provider level consult fee) is billed to you, where applicable.

Unless we hear from you, all of the Teladoc programs noted above will be included as part of our standard offering. Teladoc per consult claim charges are billed through the claim wire and will be outlined on your monthly claim detail reports.

Claim and Member Services

- **Run-In Claim Processing** – Our proposal excludes run in claim processing from the prior carrier (claims incurred before the effective date of the plan). Further, APEMT has directed us to not process such claims.
- **Runoff Claims Processing** – The expenses associated with processing runoff claims following cancellation are not included. If you request that we process runoff claims for one year, we'll charge a fee upon cancellation. The determination of the runoff fee, which is billed upon termination, is as follows:

  Average PEPM fee over the last [redacted] * the estimated average number of employees covered during the first year of your Agreement [redacted] **The PEPM fees used in this calculation are shown in the tables on pages 17 and 18.**

  Please note that the above referenced runoff charges will be waived if APEMT stays with Aetna through [redacted]

- **Medical Explanation of Benefits (EOB) Suppression** – Unless required by state law, we don't produce paper EOBs for members registered through our member website. In addition, we don't produce EOBs for claims when there is no member liability. EOBs are always available electronically through our secure member website.

- **Aetna One Advocate Medical Service Center** – We've assumed that claim administration and member services for the quoted plans will be managed centrally by the High Point, North Carolina Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 8 p.m. EST.

- **Aetna One Advocate Care Management Center** – Our Aetna One Advocate team will administer your care management services.

- **Alternate Office Processing (AOP)** – We regularly use both internal and external claim adjudication services to meet service requirements of our business. These services may be located inside or outside of the United States. Our quality standards and controls apply to all claims regardless of where they're processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design, and customer specific requirements. We may adjust fees based on the above factors and/or where you wish to limit the use of Alternative Office Processing.

- **Specialty Pharmaceutical Rebates** – We'll retain (as compensation for our efforts in administering the Preferred Specialty Pharmaceutical Program) all specialty pharmaceutical rebates earned on drug claims that we administer and pay through the medical benefit rather than the pharmacy benefit.

Network Services

- **Optional Aetna Whole Health℠ Product** – We've included the Aetna Whole Health product in our arrangement and assumed you'll participate in the following Accountable Care Organization (ACO) network(s): Aetna Whole Health New Jersey. The ACO agreement is performance based and is tied to quality and efficiency metrics. Further detail can be found in the ACO financial overview documents. These will be provided under separate cover.

- **Alternate Discount Arrangements** – In select markets, we've negotiated alternative contracts with providers and networks to provide additional savings to you and your members. These alternative contracts are available to customers that meet certain criteria and have been granted approval where applicable. Alternate Discount Arrangements cannot be offered alongside:

  - Aetna Premier Care Network (APCN)
  - Aetna Whole Health℠ Product (ACO)
  - Aexcel

  The following Alternate Discount Arrangements are offered with this proposal.

State	Alternate Discount Arrangement	Corresponding Aetna Network
[redacted]		

- **Out-of-Network Program and Reimbursement** – We have several programs to help you and your members save money when receiving care out-of-network. Outlined below is the out-of-network program we have included in this proposal.

  National Advantage™ with Facility Charge Review and Itemized Bill Review and a Medicare Fee Schedule

  The National Advantage Program (NAP includes three parts, Contracted Rates, Facility Charge Review (FCR) and Itemized Bill Review (IBR)). The Contracted Rates part offers access to contracted rates for many medical claims from non-network providers, including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers.

  We've assumed a Medicare Fee Schedule for voluntary out-of-network services. When the plan includes a percentage of the Medicare rate as the benefit level rate for voluntary out-of-network claims, NAP vendor contracted rates won't be utilized (NAP directly contracted rates may still apply). Allowed amounts based upon a percentage of Medicare rates will apply for voluntary out-of-network claims. Where a benefit is based upon a Medicare rate, and rate is not available, the claim will be referred for an ad hoc rate negotiation or FCR (as described below), as applicable. For involuntary out-of-network claims, all aspects of NAP will apply.

  National Advantage Program fees

  We'll retain [redacted] of savings and, during the year end accounting, we'll true up to a maximum of [redacted] per-employee, per month. At the end of the Guarantee Period, we'll calculate the achieved per-employee, per month fee as follows:

  Guarantee Period NAP Fees
  Enrolled employees for the [redacted] prior to the Guarantee Period

  This includes the FCR and IBR components of the National Advantage Program. Any amount above the maximum, will be included as an adjustment on your claim wire billing account. These fees are in addition to the per-employee, per-month administrative service fees.

[redacted]

[redacted]

Medicare Fee Schedule reimbursement schedule
Your proposal reflects a Medicare Fee Schedule rate for voluntary out-of-network benefits of:

- [redacted] of the Medicare rate for doctors and other health care providers
- [redacted] of the Medicare rate for hospitals and other facilities

Facility Charge Review (FCR)
FCR is a component of NAP. This component provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. Though many facilities accept the reasonable charge amount as payment in full, others may not and may balance bill the member. In the event that a member is balance billed, we have a review process and will initiate negotiations with the facility to try to come to a mutually agreeable payment amount. For claims that are to be paid at the preferred/in-network level under the terms of the member's plan of benefits (e.g., emergency services), we'll negotiate with the facility so that the member isn't responsible for charges in excess of any applicable deductible and coinsurance/copayments. However, for non-emergency out-of-network services, if we can't negotiate a mutually acceptable rate, the member may be responsible for charges in excess of the reasonable charge.
Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be paid at billed charges in certain circumstances. The program is only available in conjunction with NAP.

Itemized Bill Review (IBR)
IBR applies to inpatient facility claims submitted by our network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold we determine; and (b) our contracted rate with the provider uses a "percentage of billed charges" methodology.

We'll forward IBR Claims to a vendor to review and identify any billing inconsistencies and errors. The vendor reports back the amount of eligible charges after adjusting for any identified inconsistencies and errors. We then pay the claim based on the adjusted bill. IBR supplements our standard bill review procedures prior to claim adjudication, and currently applies to inpatient facility bills with submitted expenses of [redacted] or more.

- **Institutes of Excellence™ Transplant Network** – As part of our National Transplant Program, a registered nurse is assigned to each member to assist with every phase of the transplant process, from evaluation through post-transplant recovery. The nurse coordinates care and assists your employees in accessing covered treatment through our contracted Institutes of Excellence (IOE)

transplant network. The program also features dedicated claims and member services staff for special handling of patient claims and benefits issues. The IOE transplant network is our national network of facilities for transplants and transplant related services. Hospitals that are selected to participate in our IOE transplant network have met enhanced quality thresholds for volumes and outcomes. The charge is on a per transplant basis, whether or not an IOE facility is used. The charge is based on your specific utilization. Billing is through the claim wire process at the rate of [redacted] when a member is wait-listed for a transplant and [redacted] when a member's transplant procedure is complete. We will waive this fee if your medical enrollment with us exceeds [redacted].

- **Institutes of Quality® (IOQ)** – Our IOQs make it easy for members to choose hospitals that prioritize care quality and efficiency. Facilities in the IOQ network offer quality care for certain bariatric, orthopedic and cardiac procedures. An IOQ hospital/ facility must meet a number of industry-recognized standards for cost efficiency and clinical quality, such as:

  – Volume of procedures

  – Low rates for patient reoperation, acute hospital readmission, medical complications and death

  – Specified industry accreditations and certifications

  These factors mean higher levels of patient safety and a smoother recovery. A healthier workforce means lower costs for everyone.

  We can help you encourage utilization of IOQ facilities through a robust member engagement strategy. In addition, we recommend benefit differentials to incent members to use IOQ facilities. To implement and maintain the benefit differentials, there is a nominal annual fee of [redacted]. The quoted administrative fees do not include this charge. This charge does not include travel and lodging expenses. Travel and lodging expenses are the responsibility of the plan sponsor.

  IOQ benefit differentials cannot be offered with:

  – Aetna Whole Health Product (ACO)
  – Aetna Premier Care Network Plus (APCN Plus)*

  *You may offer IOQ benefit differential in non-ACO networks if there is separate structure for ACO and non-ACO networks

Reporting and Data Transfers

- **Aetna Informatics® Reporting and Consulting** – Based on enrollment, you'll receive a pre-determined number of support hours based on the chart below for report generation and/or consulting services in addition to our electronic tool, Aetna Health Information Advantage.

Enrollment	Support Hours
[redacted]	

[redacted]

- **Data Integration (Set-up)** – Our arrangement assumes one historical medical and one historical pharmacy data integration feed. Historical medical and pharmacy data integration feeds may be added at no additional charge.

- **Data Integration (On-Going)** – Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending on the scale of your integration needs. The quoted fees do include one (1) outgoing, monthly universal file feed, monthly reports to a third-party stop loss vendor and data intake from a third-party pharmacy benefits administrator to support benefit accumulators and our clinical programs.

- **Claims History Transfer (set up)** – These files are used to administer deductible and internal maximums. There is no cost associated with receiving claim history files electronically from the prior carrier for initial implementation. There will be a charge for files received in a format other than electronically; costs are based on the complexity and format of the data.

- **States' All payer Claims database (APCD) reporting** – Certain state regulations require insurance carriers to supply data relating to their fully insured products to that state's all payer claims database (APCD). As a result of a recent US Supreme Court ruling, and as a TPA for your self-funded plan, we are no longer required to submit self-funded plan health care claims data to states with APCDs.

  However, in some states, the law indicates that providing the data for self-funded plans is voluntary. In these circumstances, we won't provide your self-funded plan data to these states unless you inform us in writing that you wish us to do so.

- **Plan Details -** Aetna agrees to provide APEMT with copies of materials, including detailed plan design grids, that demonstrate the benefits that have been built in the system.

Legislative & Regulatory Requirements

We believe this arrangement to be compliant with all applicable state and federal laws, including health care reform.

- **Retiree Only Plan Status Certification** – Guidance issued by the Internal Revenue Service (IRS), and the U.S. Department of Labor (DOL), and Department of Health and Human Services (HHS) has indicated that "retiree only" plans are exempt from the benefit mandates under the ACA (Retiree only plans are subject to certain ACA fees and assessments). In order to demonstrate the establishment of a retiree only plan, a plan should maintain, separately from the plan for current (i.e., active) employees, a separate plan document and Summary Plan Description (SPD) and file a separate Form 5500. If you have a retiree only plan, and want to be considered exempt, please submit a retiree only certification form and required documentation to us.

  The benefits and fees within this proposal are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Account Executive.

  We reserve the right to modify products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

- **ACA Taxes and Fees – Notice of Self-Funded Group Health Plan's Financial Liability** – Any taxes or fees (assessments) related to the Affordable Care Act that apply to self-funded benefit plans will be your obligation.

GENERAL ADMINSTRATION AND MEDICAL SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- 141890
EFFECTIVE JULY 1, 2019

A. GENERAL ADMINISTRATION

This portion of the General Administration and Medical Services Schedule describes certain of the Services to be performed by Aetna for the Customer pursuant to the Agreement. The Services described in this portion of schedule apply generally to any medical, dental, pharmacy and behavioral health Plans that are subject to the Agreement. Terms used but not otherwise defined in this schedule shall have the meaning assigned to them in the Agreement.

1. CLAIM SERVICES:

(A) Aetna shall process claims for Plan benefits incurred on or after the Effective Date using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the Plan(s), any applicable provider contract, and the Agreement. Aetna shall issue a payment of benefits and related charges on behalf of the Customer in accordance with the Plan Documents and section 5 of the Agreement, for such benefits and related charges that are determined to be payable under the Plan(s). With respect to any claims that are denied on behalf of the Customer, Aetna shall notify the Plan Participant of the denial and of the Plan Participant's right of review of the denial in accordance with applicable law.

(B) Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna shall administer all claims consistent with such provisions and any information concurrently in its possession regarding duplicate or primary coverage. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the claim was incurred prior to the Effective Date. Where Customer has selected the Subrogation Program, Aetna has an obligation to bring actions based on subrogation or lien rights. Otherwise, Aetna has no such obligation.

(C) In circumstances where Aetna may have a contractual, claim or payment dispute with a provider, the settlement of that dispute with the provider may include a one-time payment in settlement to the provider or to Aetna, or may otherwise impact future payments to providers. Aetna, in its discretion, may apportion the settlement to self-funded customers, either as an additional service fee from, or as a credit to, the Customer, as may be the case, based upon specific applicable claims, proportional membership or some other allocation methodology, after taking into account Aetna's cost of recovery. The Customer shall remain liable after termination of the Agreement, for their portion of any settlement payments arising from claims paid while an active customer. Customer's liability to Aetna under this section is subject to Customer's right to indemnification by Aetna under Section12 (A) of the Agreement.

(D) If the Customer wishes to participate in Aetna's enhanced customer servicing framework as indicated in Fee Schedule, the program will be indicated as included in the Service and Fee Schedule. This initiative empowers Aetna's customer service representatives to resolve complex Plan Participant inquiries in a limited number of instances, in accordance with documented guidelines that fall within the context of Aetna's standard claims administration payment and audit procedures. The program allows an authorization of a one-time payment of a previously processed claim. The limits and requirements associated with the program are available to the Customer upon request.

(E) Plan Details - Aetna agrees to provide Customer with copies of Aetna's detailed plan design grids, upon request.

2. MEMBER SERVICES:

Aetna shall establish and maintain one or more service centers, responsible for handling calls and other correspondence from Plan Participants with respect to questions relating to the Plan, benefits, coverage and authorizations for Services under the Agreement. Aetna shall track each Plan Participant's correspondence through a permanent electronic file system that can be accessed appropriately, allowing service representatives to answer member questions immediately and shall supply Customer with detailed accounting on member call volumes including high level reasons for calls.

Aetna shall respond to inquiries from Providers regarding a Plan Participant's eligibility for benefits under the Plans and the details of such benefits as defined in the plan documents and summary plan descriptions, as amended.

Aetna shall provide full voice recording of all incoming member calls and retain such recordings in a readily retrievable format for a period of one -year from the date of the call unless required to support a legal matter, which shall be retained through resolution.

The Member Services model is as described under item 8, **Aetna One® Advocate** in B. Medical Services, of this Schedule.

3. PLAN SPONSOR SERVICES:

(A) Aetna shall assign an experienced Account Management Team to the Customer's account. This team will be available to assist the Customer in connection with the Services provided under the Agreement. Aetna shall further provide APEMT a dedicated account executive and account manager. Aetna shall additionally provide a full-time, fully-trained service person (plan sponsor liaison) that shall work Monday to Friday (usual business hours) at Concord's office in Somerset, NJ. The plan sponsor liaison shall be able to reprocess non-complex claims and assist with escalated member issues, eligibility issues, etc. Further details on the plan sponsor liaison are contained in item (K) below.

(B) Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification reasonably requested by the Customer.

(C) Aetna shall assist the Customer in connection with the design of the Customer's Plan, including actuarial and underwriting support reasonably requested by the Customer, provided that the Customer shall have ultimate responsibility for the content of the Plan and compliance with law in connection therewith. Aetna agrees to provide network details to Customer's actuary on a quarterly basis, including estimates on facility contract changes and physician contract changes.

(D) Aetna shall make member identification cards available to Plan Participants. Aetna will produce and mail ID cards for the member's initial enrollment at no additional cost. If an individual member requests a replacement card, the member will be directed to the Aetna Health digital app so they can access their ID card electronically or they will be directed to the Aetna member website so they can print an ID card. If a member changes the medical plan option in which they're enrolled and switches to a new control/suffix/account (CSA), we will generate and mail a new ID card and there will not be an additional charge. If Customer elects to reissue ID cards when it's not required from a benefit plan administration perspective or if it's for cosmetic purposes, there will be an additional fee as outlined in the Service and Fee Schedule.

Upon the Customer's request, Aetna will include third party vendor information on Plan Participant identification cards. In such event, the Customer shall indemnify Aetna, its affiliates and their respective

directors, officers, and employees from that portion of any actual third party loss (including reasonable attorney's fees) resulting from the inclusion of such third party vendor information on identification cards.

If there are customization requests beyond what Aetna has agreed to in the implementation process, Aetna will arrange for the custom printing of identification cards, with all costs borne by the Customer.

(E) Aetna shall provide the following reports to the Customer for no additional charge:

Financial & Utilization Reports	
Report	**Frequency**
[redacted]	

Banking Reporting	
Report	**Frequency**
[redacted]	

Any additional reports and the frequency, format and price for any such reports shall be mutually agreed upon by the Customer and Aetna.

(F) Upon request of the Customer, for no additional charge, Aetna shall provide either of the following services in support of the preparation of Plan descriptions:

(1) Prepare an Aetna standard Plan description, including descriptions of benefit revisions; or

(2) Review the Customer-prepared employee Plan descriptions, subject to the Customer's final and sole authority regarding benefits and provisions in the self-insured portion of the Plan.

Upon request of the Customer, Aetna shall prepare a non-standard Plan description, provided the Customer must agree in advance to reimburse Aetna for the costs of that work. If the Customer requires both preparation (1) and review (2), Aetna may require an additional charge.

(G) Upon request of the Customer, Aetna will arrange for the printing of Plan descriptions, with all costs borne by the Customer.

(H) Upon request of the Customer, if applicable, Aetna will provide assistance in connection with the preparation and update of the Customer's draft Summaries of Benefits and Coverage (SBCs). Aetna may charge for printing and mailing.

(I) The Customer acknowledges that it has the responsibility to review and approve all Plan documents and SBCs, if applicable, and shall have the final and sole authority regarding the benefits and provisions of the Plan(s), as outlined in the Customer's Plan document. Aetna shall have no responsibility or liability for the content of any of the Customer's Plan documents, or SBC's, if applicable, regardless of the role Aetna may have played in the preparation of such documents.

(J) Subject to an executed non-disclosure agreement or other data governance agreement between the relevant parties, Aetna shall provide the Customer's stop loss insurance carrier with the necessary reporting to adjudicate the claim, and the necessary data required to verify and reserve for stop loss claims, including appropriate claims and enrollment detail, clinical information and case or medical management information, as required by the stop loss carrier.

(K) Provide for a Dedicated, On-site Plan Sponsor Liaison that will support Customer and provide the Customer with on-site support at its Trust Management Company. The Dedicated, On-site Plan Sponsor Liaison will provide support on mutually agreed upon terms which shall be reviewed between the parties on a quarterly basis to ensure appropriateness to the business need, but must include the ability for On-site Plan Sponsor Liaison to adjust claims, review complex claims cases and support Customer overall on escalated cases. The parties will mutually agree on the selection of such person and such person shall execute a Non Disclosure Agreement and Confidentiality Agreement with Customer and Concord Management Resources.

4. NETWORK ACCESS SERVICES

(A) Aetna shall provide Plan Participants with access to Aetna's contracted networks of hospitals, physicians and other health care providers ("**Network Providers**") who have agreed to provide services at agreed upon rates and who are participating in the applicable Aetna network covering the Plan Participants.

(B) Aetna has value-based contracting ("VBC") arrangements with Network Providers. These arrangements reward providers based on indicators of value, such as, effective population health management, efficiency and quality care. Contracted rates with Network Providers may be based on fee-for-service rates, case rates, per diems, performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems and other provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance. Aetna will process any incentive payments attributable to the Plan in accordance with the terms of each VBC arrangement. Each Customer's results will vary. It is possible that incentives paid to a particular provider or health system may be required even if the Customer's own population did not

experience the same financial or qualitative improvements. It is also possible that incentives will not be paid to a provider even if the Customer's own population did experience financial and quality improvements. Upon request, Aetna will provide additional information regarding our VBC arrangements. This may include providing said information to the Customer's actuary.

(C) Retroactive adjustments are occasionally made to Aetna's contract rates. Retroactive adjustments may occur, for example, when the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements. In all cases, Aetna shall adjust the Customer's payments accordingly. The Customer's liability for all such adjustments shall survive the termination of the Agreement.

(D) Aetna may contract with vendors who in turn are responsible for contracting with the providers who perform the health care services, and potentially for certain other services related to those providers such as claims processing, credentialing, and utilization management. Under some of these arrangements, the vendor bills Aetna directly for those services by its network of providers at the vendor's contracted rate with Aetna, and Aetna pays the vendor for those services. In certain cases, the amount billed by the vendor to Aetna, paid pursuant to the plan, includes an administrative fee for delegated services by the vendor. As a result, the amount the vendor pays to the health care provider through the vendor's contract with the provider may be different than the amount paid pursuant to the Plan because the allowed amount under the Plan will be Aetna's contracted rate with the vendor, and not the contracted amount between the vendor and the health care provider.

(E) Aetna reserves the right to set a minimum plan benefit design structure for in-area network claims to which the Customer must comply in order to access a particular Aetna network. The Network(s) **(Choice POS II, Open Access Aetna Select, Aetna Whole Health New Jersey)** that the Customer is currently accessing do not have any such requirements. If this changes, Aetna must provide 180 days' notice of any change to allow Customer to adjust and file its plan designs.

(F) Aetna shall maintain an online directory containing information regarding Network Providers. Upon request and for an additional charge, Aetna shall provide the Customer with paper copies of physician directories.

(G) Aetna makes no guarantee and disclaims any obligation to make any specific health care providers or any particular number of health care providers available for use by Plan Participants or that any level of discounts or savings will be afforded to or realized by the Customer, the Plan or Plan Participants notwithstanding the Performance Guarantee obligations.

5. NON-DIRECT NETWORKS

If Aetna is requested by the Customer, or otherwise arranges for network services to be provided for Plan Participants in a geographic area where Aetna does not have a directly contracted network of providers (or additional access is requested or advisable), Aetna may contract with another network and or additional providers ("**non-Aetna network**") to provide the network services. With respect to the services provided by providers in the non-Aetna network ("**non-Aetna network providers**"), the Customer acknowledges and agrees that, any other provisions of the agreement notwithstanding:

(A) Aetna may not credential, monitor or oversee the providers or the administrative procedures or practices of any non-Aetna network;

(B) No particular discounts may, in fact, be provided or made available by any particular providers;

(C) Performance guarantees appearing in the agreement may not apply to Services delivered by non-Aetna providers or networks; and

(D) Non-Aetna network providers are not employees or agents of Aetna and may not be contractors or subcontractors of Aetna.

The Customer further agrees that, if Aetna subsequently establishes or expands its own contracted provider network in a geographic area where services are being provided by a non-Aetna network, Aetna may terminate the non-Aetna network contract, and begin providing services through a network that is subject to the terms and provisions of the agreement. The Customer acknowledges that such conversion may cause disruption, including the possibility that a particular provider in a non-Aetna network may not be included in the replacement network.

B. MEDICAL SERVICES

Subject to the terms and conditions of the Agreement, the medical Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Service and Fee Schedule will be provided by Aetna. Additional Services may be provided at the Customer's written request under the terms of the Agreement. This Schedule shall supersede any previous document(s) describing the Services.

Some programs are available to Plan Participants and other eligible employees as determined by Customer not otherwise covered under products provided under this Agreement ("**Employee**").

I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under ERISA necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

II. EXTERNAL REVIEW

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. The External Review process shall meet the standards of the Federal Affordable Care Act and utilize a minimum of three accredited Independent Review Organizations. Independent reviewers conduct a de novo review of the information provided to them as part of the External Review process. Both Aetna and Customer acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal, Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

The Customer acknowledges that the Independent Review Organizations are independent contractors and not agents of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

To assist in conducting such external reviews, the Customer agrees to provide Aetna with the current Plan documents, and any revised, amended, or updated versions no later than the date of any revisions, amendments, or updates.

III. [INTENTIONALLY LEFT BLANK.]

IV. CARE MANAGEMENT SERVICES

1. Specialty Case Management Programs:

- **Aetna Compassionate Care℠ Program ("ACCP")** - The Aetna Compassionate Care program provides additional support to terminally ill Plan Participants and their families. It removes barriers to hospice and provides more choices for end-of-life care so that the Plan Participant is able to spend time with family and friends outside a hospital setting.

  ACCP Enhanced Hospice Benefits Package - The enhanced hospice benefits package includes the following:
  - The option for a Plan Participant to continue to seek curative care while in hospice
  - The ability to enroll in a hospice program with a 12-month terminal prognosis
  - The elimination of the current hospice day and dollar maximum plan limits
  - Respite and bereavement services are included as part of the enhanced hospice benefits. The hospice services provided through a hospice regularly include these services and are coordinated by the hospice agency providing care and the Aetna nurse case manager who precertifies care for the Plan Participant. In addition, bereavement services are available through the Aetna Employee Assistance Program ("**EAP**") for Customers without an EAP vendor.

  Bereavement counseling shall be available to Plan Participants upon loss of a loved one, and to family and caregivers of a Plan Participant enrolled in ACCP following the death of such Plan Participant.

- **Infertility Case Management:** - Aetna operates two types of infertility programs:
  - Basic Infertility Program coordinates covered diagnostic services and treatment of the underlying medical causes of infertility, helps Plan Participants understand complex infertility treatments and helps control treatment costs through care coordination and patient education.
  - Infertility Case Management Program provides education and information resources for Plan Participants who are experiencing infertility. Depending on the plan selected, the program may guide eligible Plan Participants to a select network of infertility providers for covered or non-covered services. If the services are covered, Aetna's Infertility Case Management Unit issues any appropriate authorizations required under the Plan.

2. National Medical Excellence Program®/Institutes of Excellence™ /Institutes of Quality®:

The National Medical Excellence Program was created to help arrange for access to effective care for Plan Participants with particularly difficult conditions requiring transplants or complex cardiac, neurosurgical or other procedures, when the needed care is not available in a Plan Participant's service area. The program utilizes a national network of experienced providers and facilities selected based on their volume of cases and clinical outcomes. The National Medical Excellence Program Unit provides specialized case management through the use of nurse case managers, each with procedure and/or disease-specific training. There are two networks:

- **The Aetna Institutes of Excellence (IOE)** transplant network was established to enhance quality standards and lower the cost of transplant care for Plan Participants. It is made up of a select group

of hospitals and transplant centers that meet quality standards for the number of transplants performed and their outcomes, as well as access criteria for Plan Participants.

- **The Aetna Institutes of Quality (IOQ)** are a national network of health care facilities that are designated based on measures of clinical performance, access and efficiency for orthopedic, cardiac, and bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid or extreme obesity.

3. MedQuery®: (Encompassed Under The Member Engagement Platform, item 7 below)

The MedQuery program is a data-mining initiative, aimed at turning Aetna's data into information that physicians can use to improve clinical quality and patient safety. Through the program, Aetna's data is analyzed and the resulting information gives physicians access to a broader view of the Plan Participant's clinical profile. The data which fuels this program includes claim history, current medical claims, pharmacy, physician encounter reports, and patient demographics. Data is mined on a weekly basis and compared with evidence-based treatment recommendations to find possible errors, gaps, omissions (meaning, for example, that a certain accepted treatment regimens may be absent) or co-missions in care (meaning, for example, drug-to-drug or drug-to disease interactions). When MedQuery identifies a Plan Participant whose data indicates that there may be an opportunity to improve care, outreach is made to the treating physician based on the apparent urgency of the situation. For customers who have elected to purchase MedQuery with member messaging feature, in certain situations outreach will be made directly to the Plan Participant by MedQuery, requesting that the Plan Participant discuss with their physician, specific opportunities to improve their care.

When available information reveals lack of compliance with a clinical risk, condition, or demographic-related recommendation for preventive care, a Preventive Care Consideration ("**PCC**") is generated. The PCC is a preventive/wellness alert sent to the Plan Participant electronically via the Plan Participant's Personal Health Record. Paper copies of a PCC, delivered via U.S. Mail, are also available as an additional purchase option.

4. Informed Health® Line:

Informed Health Line provides Employees with toll-free 24-hour/7 day telephonic access to registered nurses experienced in providing information on a variety of health topics. The nurses can contribute to informed health care decision-making and optimal patient/provider relationships through coaching and support. Informed Health Line has added the Healthwise® Video Library to enhance the Employees access to health information. The Employee can be sent links to health education videos from the Healthwise Video Library, via email.

- **Nurse Information line 1-800# Only**. This includes toll-free telephone access to the Informed Health Line.

5. Enhanced Clinical Review:

Our Enhanced Clinical Review Program can limit the financial impact of high tech imaging, diagnostic cardiac, sleep management, cardiac implantable devices, interventional pain, and hip and knee arthroplasties by coordinating information provided by the ordering doctor. The information is reviewed by board-certified physicians and registered nurses, to maximize savings on these high cost services. Our Enhanced Clinical Review Program is projected to reduce unnecessary utilization by approximately [redacted]. This program is designed, through a clinical prior authorization process, to promote appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will provide these services nationally and/or regionally, and interact with, free-standing radiology and/or outpatient network facilities that provide the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance

Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion, Stress Echocardiography (Stress Echo), and Diagnostic Cardiac Catherization, Sleep Studies and Cardiac Rhythm Implantable procedures (Pacemakers, Implantable Cardioverter-Defibrillators, and Cardiac Resynchronization Therapy). The Enhanced Clinical Review program will typically be administered through relationships with third parties.

6. **Lifestyle and Condition Coaching:**
Lifestyle and Condition Coaching is part of a population health solution for Employees and their dependents which delivers a holistic, person-centric experience designed to promote healthier and more engaged employees, which in turn, drives improved organizational performance and cost savings.

The total health and well-being of each participant is monitored and analyzed using sophisticated and integrated clinical, consumer, behavioral and predictive analytics. A multi-disciplinary care team and digital toolset, helps participants to achieve their health and well-being goals with personalized support, and education.

The standard Lifestyle and Condition Coaching program offering includes lifestyle and condition management coaching. However, customers who choose to focus on lifestyle only or chronic conditions only may purchase standalone options including:

- Lifestyle and Condition Coaching: Lifestyle coaching
- Lifestyle and Condition Coaching: Condition coaching
- Lifestyle and Condition Coaching: Tobacco cessation

Lifestyle and Condition Coaching uses the Aetna Health Index to quantify the difference between the current and optimal health state for an individual or population. The difference between the current to the optimal health state is then scored and used to spot health improvement opportunities across an integrated health profile (e.g. unresolved Care Considerations, nonadherence to chronic medications, uncontrolled diabetes, at-risk for stroke, low-perception of health, etc.). With this approach, Plan Participants achieve a healthier lifestyle and better manage conditions like heart disease, type 2 diabetes, hypertension and obesity.

7. **Member Engagement Platform:**
Aetna's member engagement platform provides well-being related digital tools, programs and resources in a new comprehensive online experience designed to promote participant engagement, and includes visuals and graphics that prompt participants' interest and enthusiasm. The platform includes device integration and an online scheduling tool. Optional tools are also available, including the Rewards Center that coordinates incentive administration, and the ActiveChallenges that promote better nutrition, physical activity and weight management through team challenges.

The member engagement platform combines the following components:

- Comprehensive, proprietary health assessment
- Health Report and Health Actions
- Online digital coaching
- Personal Health Record
- Health Decision Support
- Health Trackers
- Health-related videos and online content
- Engaging tools and resources
- Social Communities

- Rewards Center
- ActiveChallenge program (buy-up option)

8. Aetna One® Advocate*:

Aetna One® Advocate is a high-touch, high-tech customer service model that combines data driven processes with the expertise of highly-trained advocates. The data that Aetna has about each Plan Participant such as medical claims, lab values, pharmacy data, precertification requests and provider relationships is combined with information from Plan Participants regarding their preferred method of communication (i.e. phone calls, emails, text messages), and the Plan Participant is paired up with an advocate team. Advocate teams may include concierge-level benefits specialists, nurses, wellbeing professionals, and provider network experts that are trained to provide support from benefit questions to complex care management. Advocates also work directly with other internal resources or programs, external vendors and network providers to support Plan Participant and their families.

Clinical services included	Administrative services included
[redacted]	

Aetna One® Advocate finds members with the greatest need that we have the best chance to help. Our program is an alternative to having separate case management and disease management programs. Our program takes member centricity to a new level through the personalization of data, risk and need. We accomplish this by focusing on the member's current and future needs, instead of reacting to specific conditions. We then help members take control of their health by providing them with the best people, tools and processes. Through one-on-one advocate support and integrated digital care, members receive help how they want it.

The Aetna One Advocate team includes two layers: [redacted] We match an advocate to each member based on what we know about a member's current needs and the advocate's specialty. As a member's needs change, their advocate may bring in an additional advocate to work with the member.

The Aetna One Advocate team uses a 360-degree member dashboard. This dashboard acts as a single source of member and plan information for all advocates. Every time an advocate works with a member, they use and update this information. They can record notes about member information, discussion points and any referrals made for easy access in the future. Using our member dashboard, advocates provide members with our next best action recommendations. These recommendations are a statement on what we recommend the member do next toward bettering their health. It can be as simple as reminding members to schedule a

PCP visit, but other recommendations can help identify an underlying health issue before it leads to a hospitalization or disability event.

Aetna One Advocate focuses on your whole population and supports those members with the greatest risks and the best opportunity for health improvement, instead of reacting to specific conditions. Our unique algorithms scan your population and find members with potential health risks. We look at a vast array of data sources including medical claims, pharmacy claims, lab data and self-reported data. From here, we identify members and then give them a risk profile - low, moderate or high. We base the profile on a combination of clinical identification and validation rules, scoring models and stratification algorithms.

Nurse support

Using a single advocate model approach, members have one-on-one phone and email support with their clinical advocate. Clinical advocates provide members with personalized support to plan and coordinate their care holistically. And we help them develop an individualized action plan with specific goals. By interacting with the same advocate the member can receive important tips and strategies to manage his or her whole health.

Digital support

Our digital resources include:

- Personal Health Record (PHR)
- Health Assessment
- Health Decision Support
- Online programs

Aetna One Advocate supports everything from clinical precertification and concurrent review to acute and chronic care management. A clinical advocate performs precertification in each advocate team. A designated utilization management team handles other utilization management functions. This team is dedicated to the Aetna One Advocate model.

Aetna One Advocate includes the following care management services:

Utilization Management:

a. **Inpatient and Outpatient Precertification:**
A process for collecting information prior to an inpatient confinement (Inpatient Precertification) or selected ambulatory procedures, surgeries, diagnostic tests, home health care and durable medical equipment (Outpatient Precertification). The precertification process permits eligibility verification/confirmation, initial determination of coverage, and communication with the physician and/or Plan Participant in advance of the provision of the procedure, service or supply at issue. Outpatient precertification is not applicable to Indemnity or PPO Products.

b. **Concurrent Review:**
Concurrent review encompasses those aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. The concurrent review process includes obtaining information regarding the care being delivered; assessing the clinical condition, providing benefit determination, identifying continuing care needs to facilitate appropriate discharge plans, and identifying Plan Participants for other specialty programs such as Case Management or Disease Management.

c. **Discharge Planning:**
This is an interdisciplinary process that assists Plan Participants as their medical condition changes and they transition from the inpatient setting. Discharge planning may be initiated at any stage of the patient management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. This program may include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.

d. **Retrospective Review:**
Retrospective review is the process of reviewing coverage requests for initial certification after the service has been provided or when the Plan Participant is no longer in-patient or receiving the service. Retrospective review includes making coverage determinations for the appropriate level of service consistent with the Plan Participant's needs at the time the service was provided after confirming eligibility and the availability of benefits within the Plan Participant's benefit plan.

Not all services are subject to utilization management. Aetna maintains the discretion as to the particular level and intensity of these utilization management programs. The services subject to utilization review may vary from time to time.

Our program uses a single National Participating Provider Precertification List. Network providers are responsible for precertification. They submit information for inpatient admissions and select outpatient procedures and services. We then use this information to verify eligibility and determine coverage.

To determine if the service is medically necessary, we use nationally approved, evidence-based clinical guidelines and internally developed Clinical Policy Bulletins (CPBs), available at aetna.com.

***For the period July 1,2019 through September 30, 2019, "Aetna Targeted Care Solutions" will be the model used by Aetna, to be replaced by "Aetna One® Advocate" effective October 1, 2019.**

Aetna Targeted Care Solutions focuses on the individuals who need our help most. Through this proactive case management solution, Aetna:

- Identifies high cost claimants to help get them the care they need
- Reduces hospital readmissions and emergency room visits
- Steers members to more cost-effective care
- Engages members to commit to long-term health improvement

Aetna supports members through designated utilization and case management teams that are focused solely on National Accounts customers. Backed by PULSE, Aetna's identification and prediction tool, our team approach ensures we engage those who need help most.

For the period July 1, 2019 through September 30, 2019, "Aetna Standard Member Services" will be the model used by Aetna, to be replaced by "Aetna One® Advocate" effective October 1, 2019.

V. BEHAVIORAL HEALTH SERVICES

1. Managed Behavioral Health:

A set of services that includes both inpatient and outpatient care management.

- Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Plan Participants for referral to a Behavioral Health Condition Management program.

- Outpatient Care Management includes precertification on a limited number of selected services. Where precertification is required, the request for services is reviewed against a set of criteria established by clinical experts and administered by trained staff, in order to determine coverage of the proposed treatment. Where precertification is not required, cases are identified for Outpatient Case Management through the application of clinical algorithms.

2. Behavioral Health Condition Management

The Aetna Behavioral Health Condition Management program identifies and engages Employees diagnosed with high-risk acute and chronic behavioral health conditions. Employees enrolled in the program get support with behavior change to improve overall functioning and wellness, which keeps them involved in and compliant with their treatment. The program promotes active collaboration and coordination of everyone involved in the Employee's medical and behavioral health care, including providers, family, friends and other Aetna clinical programs.

Triggers include: high cost claimants, re-admissions, and multiple diagnoses/co-morbidities.

3. AbleTo

AbleTo performs outreach, on behalf of Aetna, to offer Plan Participants, with certain medical conditions or those going through certain life changes, an alternative treatment setting. Outreach is made to offer behavioral health support to Plan Participants using web-based videoconferencing, online interface or telephone support, instead of a face-to-face office visit. AbleTo provides condition-specific, structured, fixed duration support. AbleTo is an in-network provider and its clinical team consists of therapists and behavioral health coaches. Each web-based videoconferencing session, online interface or telephone

support session, is subject to Plan terms applicable to a behavioral health office visit, including cost share, deductible, etc.

VI. TECHNOLOGY/WEB TOOLS

1. **Online Provider Directory:**
   Aetna's online participating provider directory--updated daily -- that anyone can use to locate network physicians and other health care providers such as dentists, optometrists, hospitals and pharmacies.

2. **Secure Member Portal:**
   The secure member portal is a Plan Participant website that can be used as an online resource for personalized health and financial information.

3. **Health Decision Support:**
   Health Decision Support provides educational support so Employees can better understand their conditions and treatment options, including tests, procedures and surgery. This helps Employees make more informed decisions for their health care.

VII. OTHER SERVICES

1. **Teladoc:**
   Teladoc is a vendor that provides access to physicians who are under contract with Teladoc, to provide consultations for non-urgent care needs by telephone. The physicians made available through the Teladoc program are independent contractors and are neither employees nor agents of Teladoc or Aetna.

2. **Subrogation Services:**
   Aetna will provide subrogation/reimbursement services when the Customer's summary plan description (SPD) is finalized, available to the Customer's employees, and includes subrogation/reimbursement language.

   Aetna does not delay processing or deny claims for subrogation/reimbursement purposes.

   Aetna has the exclusive discretion to: (a) decide whether to pursue potential recoveries on subrogation/reimbursement claims; (b) determine the reasonable methods used to pursue recoveries on such claims, except with respect to initiation of formal litigation; and (c) decide whether to accept any settlement offer relating to a subrogation/reimbursement claim. Aetna shall advise the Customer if the pursuit of recovery requires initiation of formal litigation. In such event, the Customer shall have the option to approve or disapprove the initiation of litigation. Subrogation /reimbursement services will be delegated to an organization of Aetna's choosing.

   The subrogation/reimbursement fee is outlined in the Service and Fee Schedule and includes reasonable expenses such as (a) collection agency fees, (b) police and fire reports, (c) asset checks, (d) locate reports and (e) attorneys' fees. If no monies are recovered as a result of the subrogation/reimbursement service, no fee will be charged to the Customer.

   Subrogation/reimbursement recoveries will be credited to the Customer net of fees charged by Aetna. Aetna does not credit individual Plan Participant claims for subrogation/reimbursement recoveries.

   The Customer must notify Aetna should the Customer pursue, recover by settlement or otherwise waive any subrogation/ reimbursement claim, or instruct Aetna to cease pursuit of a potential subrogation

claim. Aetna will be entitled to the subrogation/reimbursement fee, which will be calculated based on the full amount of claims paid at the time the Customer settles the file or instructs Aetna to cease pursuit.

The Customer must notify Aetna of its election to terminate the subrogation/reimbursement services provided by Aetna. All claims identified for potential subrogation/reimbursement recovery prior to the date notification of such election is received, including both open subrogation files and matters under investigation, shall be handled to conclusion by Aetna and shall be governed by the terms of this provision. Aetna does not handle new subrogation/reimbursement cases on matters identified after the Customer's termination date.

3. NATIONAL ADVANTAGE PROGRAM (NAP):

The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. Unless otherwise agreed in writing, only the NAP components selected by the Customer in the Service and Fee Schedule will be provided by Aetna. In order to elect the Facility Charge Review or Itemized Bill Review components, the Contracted Rates component must be selected.

A. **Contracted Rates Component**

Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers, or directly contracts with providers (collectively "**NAP Providers**") for (i) medical claims paid under non-network indemnity plans, (ii) claims covered under the out-of-network portion of network-based plans ("**Voluntary Out-of-Network Claims**"), and (iii) claims from out-of-network providers covered as in-network benefits under the Plan because the claims are for emergency services, because the services are provided by out-of-network providers at in-network facilities, or because Aetna otherwise determines that the Plan Participant received the services out-of-network because of circumstances outside the Plan Participant's control ("**Involuntary Out-of-Network Claims**").

When Aetna accesses rates through direct contracts or third-party vendors, the Provider is contractually bound not to balance bill Plan Participants.

In the absence of a pre-negotiated contracted rate, Aetna or a third-party vendor will attempt to negotiate a claim specific rate/discount **("Ad-Hoc Rate")**.

For Voluntary Out-of-Network Claims, allowed amounts will be based upon directly contracted rates, as available, or a percentage of Medicare rates, rather than vendor contracted rates. If a Medicare or analogous rate is not available, the claim will be referred for an Ad Hoc Rate or Facility Charge Review (as described below), as applicable. For Involuntary Out-of-Network Claims, all aspects of the Contracted Rates component will apply.

B. **Facility Charge Review ("FCR") Component**

FCR applies to inpatient and outpatient facility claims for which a contracted rate is not available and for which the claim amount exceeds a certain threshold as determined by Aetna. Through the FCR component, Aetna establishes a reasonable charge for a Plan benefit in the geographic area where such benefit was provided to the Plan Participant ("**Reasonable Charge Amount**"). The Reasonable Charge Amount is based on the Provider's estimated cost, including an anticipated profit margin. The claim will be paid based on the Reasonable Charge Amount.

FCR doesn't apply in the following situations:

- voluntary out-of-network claims unless a Medicare based plan rate is not available

- claims under [redacted] are not eligible for the program
- claims involving Medicare (when Aetna is the secondary payer) or coordination of benefits (COB) may not be eligible for this program.

C. **Itemized Bill Review ("IBR") Component**

IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna refers to these as **"IBR Claims."**

Aetna will forward IBR Claims to a vendor to review and identify any billing inconsistencies and errors. The vendor reports back the amount of eligible charges after adjusting for any identified inconsistencies and errors. Aetna then pays the claim based on the adjusted bill.

D. **Terms and Conditions**

(i) Access Fees

As compensation for the services provided by Aetna under NAP, the Customer shall pay a percentage of the amount of Savings for a claim paid under NAP (**"Access Fee"**) to Aetna as described in the Service and Fee Schedule.

(a) The Customer shall not owe any Access Fees with respect to any portion of a claim that is the financial responsibility of Aetna, such as when Aetna writes stop loss insurance and the claim exceeds the stop loss individual or aggregate attachment point.

(b) Aetna shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports.

(ii) Plan Participant Information Regarding National Advantage Program

The Customer's Summary Plan Description specifying coverage for out-of-network health services must conform to Aetna requirements. Aetna shall provide information regarding NAP Providers on Aetna's online provider listing, on our website at www.Aetna.com or by other comparable means.

(iii) Definitions applicable to the National Advantage Program:

"Ad Hoc Rate" means the rate defined in subsection A above.

"Involuntary Out-of Network Claims" means the claims defined in subsection A above.

"Reasonable Charge Amount" means the amount defined in subsection B above.

"Reference Price" means (i) for Involuntary Out-of Network Claims, the amount billed by the Provider for the Covered Service; (ii) for Voluntary Out-of-Network Claims, the benefit level set forth under the plan; and (iii) for in-network facility services where Itemized Bill Review applies, the rate for the facility service prior to removal of any non-payable charges identified as part of the claim review.

"Savings" means the difference between (i) the Reference Price, and (ii) the amount Aetna allows the provider under NAP, for services or benefits covered under the Plan affected by NAP. If Aetna pays more than the Reference Price, the Savings will be defined as zero.

"Voluntary Out-of Network Claim" means the claims defined in subsection A above.

(iv) Customer Acknowledgements

Customer acknowledges that:

(a) Aetna does not credential, monitor or oversee those providers who participate through third party contracts. Providers listed as participating in NAP through the Contracted Rates component may not necessarily be available or convenient.

(b) The following claim situations may not be eligible for NAP:

- Claims involving Medicare when Aetna is the secondary payer
- Claims involving coordination of benefits (COB) when Aetna is the secondary payer
- Claims that have already been paid directly by the Plan Participant.

(v) General Provisions

(a) Aetna's only liability to the Customer for any loss of access to a discount arising under or related to NAP, regardless of the form of action, shall be limited to the Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

(b) The terms and conditions of NAP shall remain in effect for any claims incurred prior to the termination date that are administered by Aetna after the termination date.